TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Dallas County Hospital

Respondent Name
Middlesex Insurance Co

MFDR Tracking Number
M4-16-2769-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 11, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The Requestor provided emergency room services to (claimant) on the date of 05/11/2015."

Amount in Dispute: $426.85

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 11, 2015	Outpatient hospital services	$426.85	$426.85

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital services.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
    - B7 – this provider was not certified/eligible to the paid for this procedure/service on this date of service
    - Note: The prescribing is a Non-Certified provider for Approved Doctor's list. Payment denied

- 185 – The rendering provider is not eligible to perform the service billed
- Note – Not treating doctor
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the Medicare payment rule?
3. What is the applicable rule that pertains to reimbursement?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier denied disputed services with claim adjustment reason code B7 – "This provider was not certified/eligible to be paid for this procedure/service on this date of service." The requirement of an "Approved doctor list" was abolished with the enactment of HB7, see the summary found at, https://www.tdi.state.tx.us/wc/dwc/legisupdate.html

   Approved Doctor List (ADL)(§408.023, Labor Code)

   - *Retains the ADL and the associated requirements for non-network doctors **until 9/1/2007** (or an earlier date, if determined by the Commissioner of Workers' Compensation). Network doctors are not required to be on the ADL.*
   - *However, HB 7 requires doctors, including network doctors, to comply with the Division's financial disclosure and impairment rating training and testing requirements.*

   The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. The services in dispute are for Outpatient Hospital Services with dates of service May 11, 2015. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

   > The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register.

   The Medicare facility specific reimbursement amount is explained at, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/HospitalOutpaysysfctsht.pdf as:

   > *"The payment rates for most separately payable medical and surgical services are determined by multiplying the prospectively established scaled relative weight for the service's clinical APC by a conversion factor (CF) to arrive at a national unadjusted payment rate for the APC. The scaled relative weight for an APC measures the resource requirements of the service and is based on the geometric mean cost of services in that APC. The CF translates the scaled relative weights into dollar payment rates.*
   >
   > *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) **is further adjusted by the hospital wage index** for the area where payment is being made. The remaining 40 percent is not adjusted. You may also receive the following payments in addition to standard OPPS payments:"*

   The facility specific reimbursement amount is calculated as follows:

   Payment rate found at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Addendum-A-and-Addendum-B-Updates.html

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider	40% non-labor related	Payment
96372	0437	S	$53.54	$53.54 x 60% = $32.12	0.9512 x $32.12 = $30.55	$53.54 x 40% = $21.42	$30.55 + $21.42 = $51.97
99283	0614	V	$198.39	$198.39 x 60% = $119.03	0.9512 x $119.03 = $113.22	$198.39 x 40% = $79.36	$113.22 + $79.36 = $192.58

The remaining services in dispute are reviewed as follows:

- Procedure code 80048 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 86140 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85025 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 85651 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 72100 has status indicator Q1 denoting STVX-packaged codes. This code may be separately payable only if no other such procedures are reported for the same date.
- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.

The Medicare Claims processing Manual defines the terms, Status Indicators, APC Payment Groups and Composite APCS as follows:

10.1.1 - Payment Status Indicators

An OPPS payment status indicator is assigned to every HCPCS code. The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. For example, services with status indicator A are paid under a fee schedule or payment system other than the OPPS. Services with status indicator N are paid under the OPPS, but their payment is packaged into payment for a separately paid service. Services with status indicator T are paid separately under OPPS but a multiple procedure payment reduction applies when two or more services with a status indicator of T are billed on the same date of service.

The full list of status indicators and their definitions is published in Addendum D1 of the OPPS/ASC proposed and final rules each year. The status indicator for each HCPCS code is shown in OPPS Addendum B.

10.2 - APC Payment Groups

Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. (See section 10.5 for discussion of multiple procedure discounting under the OPPS).

3. 28 Texas Administrative Code 134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent; unless
>
> (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 130 percent.

Review of the submitted medical claim finds implants were not requested. The maximum allowable reimbursement for the services in dispute listed on DWC 60 is calculated as follows:

- Procedure code 96372 has status indicator S denoting a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. The total Medicare facility specific reimbursement amount for this line is $51.97. This amount multiplied by 200% yields a MAR of $103.94.
- Procedure code 99283 has status indicator V denoting a clinic or emergency department visit paid under OPPS with separate APC payment. The total Medicare facility specific reimbursement amount for this line is $192.58. This amount multiplied by 200% yields a MAR of $385.16.

4. The total allowable reimbursement for the services in dispute is $489.10. The amount previously paid by the insurance carrier is $0.00. The requestor is seeking additional reimbursement in the amount of $426.85. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $426.85.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $426.85 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 3, 2016 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.